Contextualising co-production and co-governance in the Scottish National Health Service

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Abstract

Scotland is a small nation with strong networks and a distinct political consensus over health policy direction. Since UK political devolution in 1999, Scotland has rejected marketization/competition in favour of mutual approaches to health and social care, based on collaboration between government, citizens and health care practitioners, and inter-organisationally within and beyond the NHS. Co-production recognises citizens as owners and partners, underpinned by statutory patient rights. Examples include managed clinical networks; mental health services; a national partnership programme with citizens by Government, statutory bodies and civil society organisations (CSOs) at individual, local and national levels; and a Scottish Co-Production Network. Co-governance engages CSOs in offering advice, support and material contributions to health and social care. Growing interest in deliberative methods within mini-publics to advise government, has led to a citizens' jury to discuss and make recommendations for the ideal form and processes for shared decision-making in health care. Complexity theory is invoked to combine various theoretical frameworks to provide a set of complementary insights and possible explanations for current emergent forms. While health care quality has improved, further research is required to evaluate co-production/co-governance against other systems. Nonetheless, both citizens and Government support it to promote fairness and social justice.

Keywords: co-production; co-governance; health policy; mini-publics; complexity theory

Introduction

Public services are central to how our societies are governed and provide the lifeblood to our citizens as users of those services in order to live worthwhile lives and maximise their potential contribution. Around the world there are a number of societal features that increasingly challenge our limited ability to reform and improve those services, including increased demand and rising expectations against a backdrop of declining resources, with many social problems seemingly resistant to resolution[1], or what are commonly referred to as the 'wicked issues'. Whether these are 'wicked' in the definitional sense of Rittel and Webber[2] in the context of planning, or really examples of the kinds of complexity typically faced by governments[3], is a moot point, but nonetheless there appears to be a lack of much progress in many fields of reform.

The work of Parks et al[4] and Ostrom[5,6] has probably been the most influential in demonstrating the potential for effective local and mutual solutions to wicked or complex problems, through what has become known as the co-production of public services. Subsequent research has developed this conceptual framework[7,8] and similarly provided evidence for the benefits of a co-production approach, such as with poverty reduction[9]. Simply put, co-production describes a voluntary relationship between citizens, as service users or members of voluntary associations, service providers and governmental organisations, whereby public services are produced and delivered in partnership.

Nevertheless, despite the seeming simplicity of the terminology, there is growing concern about the multiplicity of interpretations and the various methods and assumptions that underpin diverse disciplinary interests[10]. One fundamental distinction is between individual co-production and collective organisational co-management and co-governance[11], a separation that is taken up in this paper. Co-production can involve one or more elements of

the production process, from design through implementation to evaluation and recommendations, which are considered here in respect of the core tasks of the service[12].

In order to understand the motivations, forms, processes and impacts of co-production, it is important to consider the historical, social, cultural and political context in which it operates. It is this milieu which provides the focus for this research paper, as it aims to describe and provide explanation for an emerging system of citizen engagement that brings users, providers and political authorities together in a mutual framework of public service production. The theoretical framework combines the policy advocacy coalition of Sabatier[13], with the concept of punctuated equilibrium of Baumgartner and Jones[14] and the policy streams and windows of Kingdon[15], to provide a set of complementary insights and possible explanations of the phenomena under scrutiny[16].

The macro-political systems of the state, whether they are democratic or authoritarian, offer various crucibles for the development and formulation of co-productive activity. In this paper, the example of Scotland, a devolved democratic nation within the United Kingdom (UK), will be explored with particular focus on its national system of health care within the public sector; viz. the National Health Service Scotland (NHSS). The research questions are: what form is co-production taking and why?

The structure of the paper begins with a brief outline of the establishment of the welfare state in the UK immediately following the Second World War (1939-1945) and the configuration of publicly-funded health care. More recent political devolution from 1999 provides a contemporary understanding of how party political control of government has evolved over the last 20 years. Reflecting this political backdrop, health care policies in Scotland have increasingly offered a distinct and innovative approach to trying to improve the health of the population from a relatively weak base. Key laws and strategic aims are outlined that help to

clarify the direction of travel that attempts to embody the spirit of a mutual and more localised health system.

Co-production is placed within the shift from government to governance, reflecting on traditional forms of citizen engagement towards a more empowered citizenry. Governance is understood in this context as a multi-level system, with decision-making taking place in semi-autonomous and complementary spaces involving multiple actors within the public, private and voluntary sectors. Reasons for its evolution span arguments over the hollowing-out of the state[17], declining legitimacy of democratic governments to represent citizens' interests in light of reducing voting turnouts[18], recognition of the complexity of public policy problems that require multiple inputs from various stakeholders[19], and measures to reduce the resource demands on the public purse[20], especially in times of austerity. From a contrary point of view, Bell and Hindmoor argue that governance reveals a state that is increasing its capacity to govern through hierarchical controls over a wider range of non-governmental actors[21], while Torfing et al adopt a more open approach to what they call 'interactive governance', where the state is transformed into participating and regulating the arenas of society[22]. Either way, current governance arrangements do not replace centralised governments, but may offer more effective and probably more efficient processes[23] that lead to outcomes desired by both users and those with political or professional authority.

The paper then offers some examples of co-production within health care in Scotland. In order to try to find workable solutions in situations where there is polarised opinion or conflict, innovative solutions around the use of deliberation within mini-publics are offered as a theoretical contribution, prior to making conclusions about how the Scottish context may enable this kind of development achieve the intended impacts on a sustainable basis.

Materials and methods

The analysis is qualitative and based on an interpretative case-study, adopting an abductive approach that draws on a series of policy documents, legislation and historical landmarks in the development of the health service in Scotland, from its origins in the UK National Health Service (NHS), through the devolution of Government in 1999, to subsequent reforms and strategic intentions. A developing field of deliberative and participatory democracy will offer theoretical support for many current innovations in systems of governance, some of which are developing in the Scottish context. This will be complemented by evidence drawn from research revealing public preferences for involvement and participation in health care delivery.

Evidence

UK Welfare State

At the end of the Second World War in 1945, the UK created a comprehensive welfare state to provide a range of public sector services to meet the needs of the population. These were focussed around the five 'giants', or social problems, identified by Beveridge as requiring government action[24]; viz. want, to be reduced to a minimum by a national social security system; disease, for which the National Health Service was established in 1948; ignorance, to be tackled by establishing an education system under local government control; squalor, for which a housing and regeneration strategy had already been started after the first world war (1914-1918); and idleness, which was to be tackled by policies aimed at full employment, alongside local authority leisure services. These were organised and funded by the State, largely based on taxation, supplemented by national insurance or residential contributions.

As in many countries, health care and social care have been administered separately in the UK. The NHS is run by Central Government through executive non-departmental public bodies (called 'health bodies'), while the provision of social work and community care have been allocated to local governments to manage. Table 1 summarises some of the key characteristics of this separation of public service provision. The principles of the NHS, established from its inception, are to provide services that are universal, comprehensive and free at the point of use, meaning it is based on clinically-defined need rather than ability to pay. Funding of the NHS in the UK is almost entirely through general taxation and, to a lesser extent, by National Insurance contributions, with only about 1.2% from patient charges[25].

Since political devolution in 1999, responsibility for the NHS broke into the four territorial divisions for England, Scotland, Wales and Northern Ireland, with considerable autonomy over the direction of policy being decided by the respective governments (or assemblies). This reflected historical administrative differences, but also the political will to do things differently outside England, which had dominated UK policies[26]. The resulting settlement was to retain the UK Government as deciding health policy for England alone, although the majority of funding for each part of the UK depended on a formula relating to spending levels on public services in England[27]. The three devolved territorial governments revealed increasing political separation since the devolution settlement, which is an essential turning point for understanding the implications for health care policy.

Political divergence within the UK

Focussing on the governments in Scotland compared to the UK, the common political party with a majority was New Labour, a left-of-centre party, which remained in power in both

jurisdictions until 2007. While it continued in power in the UK Parliament until 2010, Scotland saw a change to a civic nationalist agenda[28] with the election of a minority Government under the Scottish National Party (SNP). By 2010, in the wake of the financial crisis of 2008[29], the UK changed leadership to a coalition of a dominant right-of-centre party, the Conservatives, and a small centrist Party, the Liberal Democrats. A year later, in 2011, the SNP gained significantly to become a majority Scottish Government until 2016, after which it has remained in power as a minority government to the present day, supported on crucial votes by the leftist Green Party since 2016. The UK Government has remained in the hands of the Conservatives, who became a majority party in 2015, but were then forced into coalition in 2018 with the right-of-centre Democratic Unionist Party of Northern Ireland. In summary, over the last 20 years there has been a growing political chasm between the right-moving government in the UK, dealing with England's health policy, and the left-moving government in Scotland.

Scotland is a relatively small country, both in terms of land area (78,387 km^2) and population (5.4 million in 2016). It is a developed, post-industrial nation with an estimated 2016 gross value-added per capita of ¥218,000. Expenditure per capita on the NHS in Scotland is ¥19,000 (2015 estimate) and the whole-time equivalent staffing is 138,000 (mid-2016 estimate). From the beginning of the establishment of the Welfare State in 1948 until political devolution in 1999, there was a large degree of administrative devolution, although the Scottish Office, the arm of the UK Government in Scotland, developed health policies that largely mimicked the ones in the rest of the UK. From 1999, control over health policy was devolved to the Scottish Executive (later Scottish Government), although responsibility for fiscal policy did not follow until 2016. These changes, coupled with the changes in political control in each of the four nations, have opened up the potential for considerable policy divergence across the UK.

A clear difference between England and Scotland is to be found in the economic orthodoxy that underpins the two nations and, therefore, the policy instruments at their disposal. Under New Labour, England followed the path of the 'Third Way'[30], combining what it saw as the strengths of each arm of the traditional division between markets and government control. Nonetheless, despite some fundamental differences, it further developed the previous Conservative Government's neo-liberal project in its belief in improving quality of health care through competition, encouraging a mixed economy of providers, including Independent Sector Treatment Centres, a purchaser-provider split through the development of an internal market, patient choice of provider, and payment of professionals and managers by results. Scotland took a different route, based on ideas of mutuality, collaboration and partnership working that reflected a belief in collectivist ideas to achieve improvements in quality combined with social justice. The purchaser-provider split was abolished, with Health Boards returning to funding and providing services, and private contracts were banned through legislation, except those that had already been agreed under the former Private Finance Initiative. More recently, Scotland has led the way in legislating for Integrated Health and Social Care Boards that bring many of the central and local government services into a common framework with shared financing.

A key driving force behind this approach has been the perceived need to improve quality of service delivery and health outcomes. Scotland has one of the worst health records of any developed country, with the lowest[31] (and currently declining[32]) life expectancy in western Europe, and high levels of obesity, mortality from circulatory diseases and alcohol-related mortality and morbidity[33]. High and increasing inequality shows a difference of over 22 years in average life expectancy between the most and least deprived deciles of the population[34]. The integration of health and social care was seen as providing a more

effective route into improving the health of the Scottish population that did not rely on previous models of health care[35].

Policy developments in Scotland

The newly devolved government in Scotland set out an ambitious and radical plan[36] to change the culture in the Scottish health services (now re-labelled as NHSScotland (NHSS)), which were brought under their control. The intention was to change how services are delivered and the nature of the interactions with the public. There was considerable focus on ensuring that citizens, individually and collectively, had a meaningful role in the NHSS. This was partly about ensuring that the services respected people as individuals involved in their own care, such that they were designed for and involved users. It was also intended to have an approach where individuals (as patients, carers, volunteers, or citizens more generally), groups and communities are involved in improving the quality of care, influencing priorities and planning services. This policy intent was given strength by the assertion that:

> …listening, understanding and acting on the views of local communities, patients and carers is given the same priority as clinical standards and financial performance.[37]

This early statement of intent was quickly followed by further developments in health service policy[38] that aimed to build capacity and communications, patient information, responsiveness and involvement. This last point underpinned a commitment to co-production through asserting that communities, patients, members of the public and NHSS staff should have opportunities to influence decision-making. It also established the Scottish Health Council, whose role was to both provide guidance to the Health Boards in relation to good practice in citizen involvement, and to monitor the practice and outcomes. There were two drivers of this particular policy which were of particular note. One was the concern that,

while increasing personalisation in health care was desirable from an ethical point of view, health service resource allocation could be distorted by allowing individuals complete choice, given the unequal access and resources at their disposal. Thus, the plan underlined the collective approach through broader public involvement that would aim to ensure services were focussed on the needs of individual patients. The second driver was the recognition that a people-centred service should include those who worked in it, thus aiming to prevent an adversarial position between users and providers, and pooling their collective knowledge and understanding as different stakeholders in the process.

Health Board duties relating to public involvement and equal opportunities were further strengthened in reform legislation in 2004[39]. The Chief Executive of the NHSS provided updated guidance in 2010[40] to Health Boards, supplemented by guidance from the Scottish Health Council[41], on the legislative and policy frameworks for informing, engaging and consulting with the public, who were recognised to include health service users, patients, staff, members of the public, carers, volunteers and their organisations. Health Boards are also expected to follow the National Standards for Community Engagement developed and updated by the Scottish Community Development Centre[42], a non-profit organisation promoting inclusive communities.

More recent health care reforms have aimed to strengthen social solidarity and to promote equity of outcomes, through building on a collaboration and partnership between government (central and local), health and social care services, professionals and civil society[43]. The SNP, elected into Government in 2007, identified enabling a healthier population as one of its five strategic objectives for public services. In the light of this, they produced a quality strategy[44] to improve the health of everyone, the quality of health care and the health care experience, which was to be based on a *mutual* NHS as the underpinning requirement of a person-centred health care system. This was purposely designed as being in

contradistinction to the neoliberalism of English reforms based on competition and markets in health care, either internal or external[45]. In parallel, the SNP put in place measures to maximise the contribution of NHSS and local government to meet the goals of the Scottish Government, through Single Outcome Agreements for the Community Planning Partnerships[46], based on "mutual respect and partnership"[47].

Quality improvement in health care services has been at the core of the Scottish Government strategy for the NHSS, and, since 2010, has revolved around three key drivers: person-centred, safe and effective[48]. Person-centredness aims at "mutually beneficial partnerships between patients, their families and those delivering healthcare services which respect individual needs and values and which demonstrate compassion, continuity, clear communication and shared decision-making"[49]. This builds on prior research on health service users' views of what is important in their care[50] and legislation that was enacted to assure patients of their rights and responsibilities within the NHSS, in order to improve their experiences and to enable them to become more involved. The intended impact has been to improve access and to promote equality of experience and outcomes for everyone in Scotland.

A major boost to these strategic developments came through the Commission on the Future Delivery of Public Services in 2011 (Christie Commission)[51], from which a key principle for the recommended reforms aimed "…to empower individuals and communities receiving public services by involving them in the design and delivery of the services they use[52]". The report emphasised the need for public services that are focussed on outcomes, prevention and early intervention, integrated, transparent, collaborative, community-driven and designed around users' needs[53]. This was followed by the strategic vision for achieving the Quality Strategy based on prevention, anticipatory care and supported self-management by health care users, within an integrated health and social care system[54]. The realisation of this latter

requirement came about through legislation in 2014[55], which required the pooling of budgets between health and social care, and a single point of oversight and accountability over the delivery of care. More recent legislation which came into force in 2018 requires the NHSS to involve carers when making decisions relating to hospital discharge[56].

A major piece of legislation designed to support communities to do things for themselves and to make their voices heard in the planning and delivery of services is the Community Empowerment Act of 2015[57]. It stipulates the requirement for Government to ask citizens every five years what should be the national outcomes to be aimed for, in order to provide a vision of the kind of society that is desired by the people of the country. Partnerships between local authorities and citizens are the basis for community planning, with community groups empowered to make participation requests if they have ideas for improving public services. Participation in public decision-making is written into the legislation, although there are limits placed on which decisions they can share.

While there have been formal changes to health and social care delivery, there has been a clear move towards a heightened degree of multi-agency collaboration across public services, including health, social care, education, justice and the police, but also including civil society as represented through voluntary and community groups across Scotland. These developments indicate the move from government to governance in the public sphere, as governments search for service quality improvements within a context of increasing demands, resulting from an ageing population and developments in medical technologies, and constrained resources, arising from the global financial crisis of 2008. The increasing complexity of problems demands wider stakeholder engagement to search for workable solutions that satisfy all sectors of society, driven in part by the increasing questioning of the legitimacy and authority of government[58]. Partnerships between government and civil society have led to the current interest in co-governance arrangements, which, as Ansell and

Gash determined from their meta-analysis of 137 articles[59], often arises due to the failures of policy implementation and the high costs and politicisation of regulation. At the micro-level, patients, informal carers and volunteers are increasingly invited into sharing understandings and decision-making, while at the same time expected to share in the responsibilities that this entails, through the process known as co-production. A Government review of the Scottish approach to improvement in health care has, alongside other factors, identified the success of having multiple stakeholder groups involved in co-production, including some examples of co-design of interventions[60].

Citizen involvement in health service policies

Citizens can be seen to hold several stakes in the society of which they are a constituent part, not least in relation to health services. As individuals, they may be service users, which encompasses the roles of patients and lay carers (typically family members), or simply people who feel an obligation to play their part in making services better for others in society. At the level of civil society, people often play multiple roles, as members of community groups, voluntary organisations, social movements, political parties, or trade/labour unions.

There are a number of arguments which can be raised for and against citizen involvement in health services. Firstly, there are strong practical reasons for their inclusion in continuous quality improvement activities. They not only provide additional viewpoints to those proffered by professionals and managers, but fundamentally it gives recognition to the values, lived experiences and preferences of patients, carers and advocates as providing expertise otherwise hidden from view. As argued by Osborne[61], it is the interaction of these experiences with the public service offerings that creates value, not the offering in itself. Additionally, there is a wealth of evidence to demonstrate the 'wisdom of crowds', whereby

collective intelligence drawn from individual judgements is superior to the judgement of a few professional experts[62].

The second positive argument is that there is a political and ethical norm that requires citizen involvement, insofar as to be a citizen demands some responsibility being taken for the conduct of their lives and in turn there has to be some accountability for the way services are provided to them. It is now recognised as a *sine qua non* of patient involvement that there should in policy-making be 'nothing about us without us', or, in other words, all stakeholders (or their accepted proxies) should be included in decisions that affect them[63].

Nonetheless, there are a number of concerns and criticisms of citizen involvement that deserve attention. The first of these arguments can be starkly summarised as stating that citizens, especially those who self-select or promote a cause, are unrepresentative of users or indeed the general public. They typically do not reflect the diversity of citizens and have varying levels of cultural and economic capital that does not necessarily promote the collective interest. A commonly used soubriquet is of the 'usual suspects', terminology that seeks to denigrate or question the extent to which citizens, who are constantly prepared to be actively involved, can provide the valuable insights required to reflect the broader constituency of stakeholders. Even among citizens themselves, there has been a growing gulf between 'expert citizens' and 'everyday makers' as a result of governmental strategies aimed at inclusion[64].

The second line of argument against citizen involvement is aimed at the inefficiency that this creates for both the citizen and the public services. Fundamentally this is based on a belief that involvement is a time-consuming activity that requires both citizens and public service employees, particularly professional experts, to expend unnecessary effort to ensure everyone is on board with the decisions, which may become sub-optimal as a result. This in turn

makes the process much more expensive, even assuming that citizens help to develop better decisions by their involvement. The third negative criticism argues that canvassing a wide range of views, as is often the case, without the likelihood of any agreement, demonstrates that citizen involvement is impractical for the realities of public sector management.

While there are clear signs of government opening up spaces for collaborative activity, or what are termed 'invited spaces'[65], it requires a willingness and enhanced level of trust by citizens to fulfil their side of the relationship. To a large extent this will depend on previous experiences of interaction with public services, a belief in the commitment of authorities to provide a genuine sharing of the decision-making process, and a sense that they can make a productive contribution to the process.

Drawing on longitudinal qualitative research conducted in Catalonia and England, using interviews, focus groups and interactive workshops, Thompson investigated how involved citizens wished to be in health services, from service delivery to policy making[66]. In general, patients who were not affiliated to any civil society organisations were less knowledgeable and assertive, expressing greater need for support and advocacy, than those with more social capital. Their primary attention was at the level of service delivery, in particular relating to issues of access, quality of services and how to improve relationships with professionals, largely around time and continuity of care, issues which offer fertile ground for co-production. Civil society organisation members, by contrast, were generally more confident and assertive in their desire for involvement, with a greater emphasis on policy and planning as the focus for their activism. Their primary aims were for more channels for representation in policy-making, changes in working practices of statutory bodies, greater investment in support and training for lay citizens, and a role in developing and implementing involvement. These aims signify a strong desire for co-governance arrangements.

Overall, citizens were spread across a range of levels of desired involvement, from non-involvement, through information-seeking, information-giving, and shared decision-making, to autonomous decision-making[67]. The level of involvement they preferred varied over time and depended on a number of characteristics, including their need for health care, in terms of type (acute or chronic) and severity of illness; certain personal characteristics, including knowledge, experience and personality type; and how much trust they had in the relationship with their professional health care provider.

Examples of co-production in Scotland

The challenge laid down in the Scottish Government policy for a mutual NHS was the following:

> We need to move, over time, to a more inclusive relationship with the Scottish people; a relationship where patients and the public are affirmed as partners rather than recipients of care. We need to move towards an NHS that is truly publicly owned…where ownership and accountability is shared with the Scottish people and with the staff of the NHS…where we think of the people of Scotland not just as consumers – with only rights – but as owners – with both rights and responsibilities.[68]

This has required underpinning legislation that supports greater patient and carer involvement[69], as well as a Participation Standard for Health Boards[70] to judge how well they include citizens, as patients and members of the public. The changing governance arrangements in Scotland have undoubtedly opened up spaces for citizen involvement over the last twenty years, particularly in health care. Levels of engagement vary but there are a number of examples of co-productive activity where service users are key players in helping to forge a new relationship with service providers on the basis of a mutual partnership.

One of the most important strategic developments was based on a vertical partnership between service providers, called Managed Clinical Networks (MCNs), which are co-ordinated groups of health professionals and organisations working to ensure equitable, high quality, clinical services. These MCNs, of which there are over 130 currently (21 at the national level[71]), are based on specific health conditions, such as diabetes. Patients with experience of the condition and their carers, as well as related patient groups, are important members of the teams. A review of MCNs[72] concluded that their success in improving the quality of care was largely related to the changes in the culture of practice, with softer, non-contractual factors of relationship building, facilitation, persuasion and influence resolving some of the challenges presented by "the 'wicked problems' of care integration and coordination"[73]. A further example is found in the co-design of priorities for mental health services by users, carers and clinicians in order to improve the safety of health care and reduce levels of harm[74].

The Scottish Health Council had the responsibility for developing a national programme, called 'Our Voice'[75], as a partnership between citizens, the Scottish Government, NHSS, local government and civil society, operating at three different levels. At the individual level, it aims to ensure patients and carers are fully involved in treatment and care decisions, with feedback used to inform continuous quality improvement. At the local or community level, it assists with the development and support of peer networks in local planning, building capacity for involvement and leadership. At the national level, the aim is to develop a hub to gain knowledge of the issues of concern, to enable a strategic analysis of stories for policy-makers and professionals, and the development of citizens' panels to engage in national policy debates. This is reinforced by a leadership coalition of users, carers and leaders from NHSS, local authorities and civil society, who together provide guidance, maintain momentum and champion citizen voice in their respective organisations.

It is worth noting that not all the spaces for citizen involvement are being created by public services, even though they have many of the resources and current responsibilities for delivering health care. There is also a growing interest from civil society organisations in creating 'claimed spaces' from the grassroots[76], where voluntary organisations are engaged to agree collective positions and to take action, such as the promotion of their involvement in community planning initiatives[77]. Resulting from contact between a Scottish Health Board and the New Economics Foundation in 2010, a Scottish Co-production Network[78] has been established to share learning and the exchange of practices across Scotland, in order to promote this way of working.

One of the problems to be overcome is to find ways to enable the 'wisdom of crowds' to be articulated in meaningful ways in the context of co-productive activity. Increasing interest is being shown in more innovative forums, such as mini-publics, which are random selections of citizens to reflect the diversity of specific sub-populations around particular topics. Deliberative techniques are used to enable open talk to resolve conflicts and solve problems, rather than adversarial bargaining, suppression, or thoughtless neglect of the range of participants' views. It is based on the premise that collective decisions should be made through informed, reasoned discussion, rather than the sum of individual, private preferences[79]. This approach moves citizens from consumers shopping in the market of ideas, through pre-formed preferences which are often uninformed or unconsidered reactions, to citizens negotiating the meaning of the public good through equitable and rational processes. This offers opportunities for a more reflective engagement through learning, talking, listening and debating.

This innovation reveals increased levels of self-efficacy in participants in making complex decisions and developing a sense of empowerment and valuable contribution to the common good. In terms of governance, it can be combined with other forms of involvement to enrich

the discussions from an informed and rational position, rather than reflecting vested interests. It also helps to increase the legitimacy of decisions, since it can be seen by other citizens as offering a proxy for themselves, given its diversity of membership. Moreover, it offers opportunities for learning new ways of working for all groups in the co-production exercise.

Building on this approach to citizen involvement, the Chief Medical Officer (CMO) for Scotland, on behalf of the Scottish Government, sponsored the pilot of a citizens' jury, a particular form of mini-public [80], to consider how members of the public would tackle a major aim of NHSS strategy around the concept of realistic medicine[81], a personalised, patient-centred approach to care. A random selection of 24 demographically diverse citizens was invited to attend a series of three consecutive juries, spread over a period of 8 weeks, to learn about and to deliberate on the question:

> 'What should shared decision-making look like and what needs to be done for this to happen?'[82]

In conclusion, the citizens' jury came up with 13 recommendations for policy, to which the Government had made a commitment to respond and explain the reasons for their adoption, delay, or rejection. It is likely that, without this final response by Government, citizens would become cynical and less inclined to participate in co-productive activities, as it would be seen as providing a smokescreen for true citizen involvement. The recommendations formed six different themes:

> Informing, educating and preparing patients to ask questions;
>
> Creating the culture for shared decision making, including adequate finances, resources and support;
>
> The organisation of appointments;
>
> Training for professionals;
>
> Advocacy by independent people to assist patients in conversations with professionals;

Patient's information and records.

The CMO responded within 4 months by a commitment to take all but one recommendation forward, giving details of what was already in place and what would be developed to ensure progress[83]. The single exception concerned the practical problems of consistently providing continuity of care from the same professional, although this was supported in principle, with strategic commitments to improve access to multidisciplinary teams, further develop a national digital platform, and extend the work already undertaken in maternity services. There are plans to evaluate the mini-public in relation to the process and the outcomes of its recommendations. Further use of this type of deliberative forum may be seen in years to come, depending on its perceived value in creating a mutual approach to policy development.

In summary, the Our Voice framework, coupled with deliberative approaches, such as this example of a mini-public, offers an ambitious and potentially productive foray into the uncertain and risky world of co-production[84].

Discussion

In assessing the reasons for the favourable context for the initiation and embedding of co-production and co-governance in Scottish health policy, this analysis draws on the central role of ideas in policy development[85], whereby the policy, problem and politics streams coincide, giving rise to windows of opportunity. Differences exist in the policy conditions over time and with respect to other linked nations and institutions, as well as there being a receptivity to ideas that may provide solutions to perceived lack of progress in resolving wicked issues.

In adopting Kingdon's framework[86], we can identify two salient problems facing Scotland. The first is the relatively poor health outcomes of its people in relation to other countries in Western Europe, with a growing health inequality gap, that seemed immune to existing policy solutions that were being promulgated in the UK. The second is the effect of new public management since the 1980s and the global financial crisis in 2008, which led to economic austerity programmes adversely affecting the public purse. In relation to the policy stream, there were two developments which were occurring in the health care professional arena: an emerging global consensus about the importance of involving patients and the public in health care development and implementation; and the value of shared decision-making between patients and practitioners. The Scottish Government invited the Institute for Healthcare Improvement in Boston, USA, to act as a policy broker and bring ideas to bear on health policy development that fostered these approaches. The final levers that opened the window of opportunity were in the political stream, with a change of direction in the governing party and related ideology, linked to political devolution in 1999, and accelerated by a change in party, which coincided with a desire to show clear policy differences to its nearest neighbour, England. Remarkably, there has been little dissent between the political parties to the direction of change.

A belief that the UK Parliament would never represent the views and interests of Scotland created the climate for a referendum on Scottish independence, narrowly lost in 2014, and overall opposition to Brexit, the UK referendum on independence from the European Union in 2016. These beliefs and the role of promising new ideas for breaking the policy inertia in resolving the poor health of the nation, against a backdrop of adverse external socio-economic conditions, led to an advocacy coalition of politicians, professionals and civil society groups with a common aim in mind[87]. The small size and highly networked society in Scotland made possible the bringing together of ideas and people to make it happen.

The juxtaposition of these various factors created the conditions for the profound changes in health policy, or punctuated equilibrium[88], that moved Scotland in a distinctly different direction to England and many other neo-liberal states. Complexity theory[89] may possibly provide the best account of the reasons why Scotland has moved in the direction of co-production and co-governance, insofar as it shows how different streams can coincide to provide the necessary stimuli for change in an otherwise path dependent system based on historical policy uniformity. The emergent policies reflect the opportunities afforded Scotland after the development of the multi-level governance structure in the UK.

Conclusions

What is evident from these examples of co-production in Scotland is the importance of a number of contextual factors that come together in a particular space and time to allow such approaches to be developed with the support of a wide range of actors. Scotland has a recent history of poor health, albeit improvements are being made due to specific policies around public health and health services. This factor, together with a broad political consensus over the direction of change from political parties across the spectrum and civil society, providing support for public sector solutions and partnerships with local communities through community groups and voluntary organisations, gave the impetus for a radical change to normal practice. Scotland also benefits from a small population that is tightly networked, meaning that all stakeholders can be brought on board to share in the vision. The emphasis on organisational stability, rather than the continual reforms imposed in England, encouraged the growth of vertical and horizontal integration through partnership working, rather than the fragmentation and adversarial systems promoted by markets and competition. It is too early to say whether such joined-up working delivers a better set of health outcomes than found

elsewhere, but the evidence does suggest that co-production and co-governance point the way to a more acceptable way of working and engaging the citizens of the country in a mutual enterprise of fairness and social justice.[90]

Acknowledgments

This work was carried out as part of my standard contract of employment without additional grants.

Declaration of interest statement

There is no known conflict of interest.

Biographical note

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Word count

8889 words

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Tables

Table 1 State health and social care in the UK[91]

	Health care (NHS)	**Social Work and Community Care**
Policy locus	Central Government	Local government
Accountability	Government minister	Elected local councillors
User charges	Free at the point of use	Means-tested
Physical limits	GP catchment area	Local authority boundary
Emphasis	Individual (medical) cure + Collective public health	Individual care within social context

Notes

[1] Boyle and Harris, *The challenge of co-production*.
[2] Rittel and Webber, *Dilemmas in the general.*
[3] Peters BG, *What is so wicked.*
[4] Parks et al, *Consumers as co-producers.*
[5] Ostrom E, *Crossing the great divide.*
[6] Ostrom E, *Beyond markets and states.*
[7] Bovaird, *Beyond engagement and participation.*
[8] Alford, *The multiple facets.*
[9] Ferlie et al, *Public policy networks.*
[10] Brandsen and Honingh, *Distinguishing different types.*
[11] Brandsen and Pestoff, *Co-production, the third sector.*
[12] Brandsen and Honingh, *Distinguishing different types*, 432.
[13] Sabatier, *The advocacy coalition framework.*
[14] Baumgartner and Jones, *Agendas and instability.*
[15] Kingdon, *Agendas, alternatives and public policies.*
[16] Cairney, *Standing on the shoulders.*
[17] Rhodes, *The hollowing-out of the State.*
[18] Norris, *Democratic deficit.*
[19] Wagenaar, *Governance, complexity and democratic participation.*
[20] Stoker, *Governance as theory.*
[21] Bell and Hindmoor, *Rethinking governance.*
[22] Torfing et al, *Interactive governance.*
[23] Warren, *What can democratic participation mean.*
[24] Beveridge, *Social insurance and allied*.
[25] Hawe and Cockcroft, *OHE Guide to UK,* 45.
[26] Greer, *Devolution and health policy.*
[27] UK Parliament, *The Barnett formula.*
[28] Mason, *Community, Solidarity, and Belonging.*
[29] Mathiason and Stewart, *Three weeks that changed.*
[30] Giddens, *Beyond left and right.*
[31] Dodds, *Ten years of GCPH.*
[32] National Records of Scotland, *Latest estimates indicate life*.
[33] Mesalles-Naranjo et al., *Trends and inequalities.*
[34] Steel and Cylus, *United Kingdom (Scotland): health.*
[35] Fooks et al., *Integrating care in Scotland.*
[36] Scottish Executive, *Our National Health.*
[37] Scottish Executive, *Our National Health*, 50.
[38] Scottish Executive, *Patient Focus*.
[39] Scottish Parliament, *NHS Reform (Scotland)*.
[40] Scottish Government, *Informing, engaging and consulting*.
[41] Scottish Health Council, *Involving Patients, Carers*.
[42] Scottish Community Development Centre, *National Standards for Community*.
[43] Thompson and Steel, *Partnership and collaboration*.
[44] Scottish Government, *Better health, better care*.
[45] Thompson and Steel, *Scotland*.
[46] Scottish Government, *Scottish Budget Spending Review.*

[47] Scottish Government, *Scottish Budget Spending Review,* 1.
[48] Scottish Government, *The Healthcare Quality Strategy*.
[49] Scottish Government, *The Healthcare Quality Strategy*, 7.
[50] Scottish Government, *Better Together*.
[51] Scottish Government, *Commission on the Future*.
[52] Scottish Government, *Commission on the Future*, vi.
[53] Scottish Government, *Commission on the Future*, 22.
[54] Scottish Government, *20-20 Vision*.
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[56] Scottish Parliament, *Carers (Scotland) Act*.
[57] Scottish Parliament, *Community Empowerment (Scotland) Act.*
[58] Grönlund and Setälä, *Low electoral turnout*.
[59] Ansell and Gash, *Collaborative governance in theory.*
[60] Scottish Government, *The Scottish improvement journey*.
[61] Osborne, *From public service-dominant.*
[62] Surowiecki *The wisdom of crowds*.
[63] Charlton, *Nothing about us without*.
[64] Bang, *Among everyday makers.*
[65] Cornwall, *Locating citizen participation*.
[66] Thompson, *The meaning of patient.*
[67] Thompson, *The meaning of patient.*
[68] Scottish Government, *Better health, better care*, 5.
[69] Scottish Parliament, *The Patient Rights*.
[70] Scottish Health Council, *A participation standard*.
[71] NHS National Services Scotland, *National Managed Clinical Networks*.
[72] Guthrie et al., *Delivering health care.*
[73] Guthrie et al., *Delivering health care,* 205.
[74] Healthcare Improvement Scotland, *Scottish Patient Safety Programme*.
[75] Scottish Health Council, *Our Voice: working together*.
[76] Gaventa, *Finding the space.*
[77] STRiVE, *STRiVE: Third Sector Interface*.
[78] Scottish Community Development Centre, *Scottish Co-production Network*.
[79] Parkinson, *Why deliberate?*
[80] Jefferson Center, *How we work*.
[81] Scottish Government, *Realising realistic medicine*.
[82] Scottish Health Council, *Our Voice citizens' jury*.
[83] Scottish Government, *Realistic medicine.*
[84] Norris, Thompson and Steel, *Deliberative engagement*.
[85] Cairney, *The role of ideas.*
[86] Kingdon, *Agendas, alternatives and public policies*.
[87] Sabatier, *The advocacy coalition framework.*
[88] Baumgartner and Jones, *Agendas and instability.*
[89] Geyer and Cairney, *Handbook on complexity.*
[90] The considerable attention to the political changes and policy developments in Scotland, rather than a focus on the theory of co-production/co-governance, has been given in order to provide a deeper understanding of the contextual conditions that might underpin the emergence and sustainability of collaboration and partnership in whatever form it takes. The abductively-developed hypotheses derived from complexity theory about why this might take this particular form in Scotland require further testing, as does the need to conduct

comparative research on its generalisability to other systems and regimes of health care delivery.

[91] Adapted from Glasby, *Understanding health and social.*